PAUL GOOD PH.D.
1738 Union Street, Suite 300
San Francisco, CA 94123-4425

Specializing in Clinical
& Forensic Psychology
CA License PSY 7994

(o) 415-346-0607
(e) paulgoodphd@gmail.com

October 17, 2010

Mr. Donald Bergerson
Attorney at Law
766 Capp Street
San Francisco, CA 94110

Re: Aspillera, Lily

Dear Mr. Bergerson:

Pursuant to your request, I have examined Ms. Aspillera for the purposes of assessing her mental state, now and at the time of the offense. In addition, you have asked that I determine if there are factors in mitigation that would be important for the trier of fact to consider.

Prior to the evaluation the consent and release forms were reviewed and signed. Explanations regarding the likely or possible uses of the information collected, the limits on confidentiality, and Ms. Aspillera's right to withdraw her consent and right to counsel were provided to her. She acknowledged that all of her questions were answered to her satisfaction and she agreed to participate under the circumstances.

EVALUATION PROCEDURES:

1. I spoke by telephone with Mr. Bergeson to get the facts of the case and relevant information;

2. I interviewed Ms. Aspillera on September 14, 2010 and September 21, 2010 at my office;

3. I administered the following psychological tests to Ms. Aspillera on September

14, 2010 and September 21, 2010: Shipley Institute of Living of Scale-2; Beck Depression Inventory-II; Rotter Incomplete Sentences Blank; Millon Clinical Multiaxial Inventory-III (MCMI-III), California Psychological Inventory (CPI).

BACKGROUND INFORMATION:

Ms. Lily Aspillera is a 66-year-old married Filipina woman charged with multiple counts of mail fraud and tax evasion stemming from the embezzlement of funds from a client over a four year period, from 2004-2008. She plead guilty to the charges and is now awaiting sentencing in Federal court.

Ms. Aspillera was hired by Ernst & Young in 1999 as an Executive Assistant at an annual salary of about $65,000. She rose quickly to become a client service specialist and by 2004 was making about $120,000. She was considered a careful and meticulous employee. She serviced assets of high net worth clients with whom she met approximately once per week. At the home of her clients, she would write checks, pay bills, handle administrative and accounting chores.

Beginning in 2004 or 2005, Ms. Aspillera began to write checks to herself from one client she was servicing. She estimates writing about one check to herself per week. Over approximately four years, ending in June 2008, the amount embezzled was between $1.7 million and $2.9 million. The crime was discovered after an errant bank statement made its way to the client. Shortly thereafter, Ms. Aspillera left Ernst & Young following two transient ischemic attacks (TIAs) at work, which led to her being placed on disability. She has not worked since 2008.

Ms. Aspillera expressed strong feelings of remorse and regret. She stated, "People gave me so much trust and I betrayed that trust..." Ms. Aspillera reports feeling "horrible" about her offense: "I feel so guilty...I've been very trustworthy all my life. I hate myself." She acknowledged that she has no one to blame but herself. This woman accepts full responsibility for her actions.

She is upset thinking that the victim "hates" her, and she is aware of the hurt and embarrassment that her actions caused her husband and children as well. Ms. Aspillera describes herself as a practicing Catholic who "fell from grace" and "fell into sin" in committing her offenses. Despite her noble intentions to help her sister, she stated "I committed a crime. It is a sin against God and humanity."

One year before she started to embezzle funds from her client, Ms. Aspillera's life

began to unravel out of control, as life threatening illness attacked her family and herself. The stressful circumstances in both her immediate and extended family stretched from 2003 to 2008, when the crime was discovered, and continue to the present.

For example, Ms. Aspillera underwent an angioplasty in 2003 for a blocked artery. In January 2004 she learned of her sister's Stage 4 breast cancer. In May, her niece died of Lupus. In June, her brother-in-law died of lung cancer. And in September, Ms. Aspillera had a massive heart attack due to clogged arteries. She required quintuple bypass surgery over a three month span. In 2005, her sister's breast cancer disease spread to her bones. In February 2006, another blockage in one of Ms. Aspillera's arteries precipitated a second angioplasty and insertion of a stent. In August 2007, her sister succumbed to breast cancer and died. In February 2008, her husband developed heart disease, i.e., viral cardiomyopathy. In 2009, his illness went from bad to worse, he was in and out of the hospital, and he is now suffering with congestive heart failure. And finally this year, Ms. Aspillera's husband had brain surgery for a subdural hematoma, and another brother-in-law died in a fatal car accident.

Ms. Aspillera offered some information that is relevant for how she got caught up in the crime. Her husband had stopped working in 1995 and she was supporting the family. Her heart attack and quintuple bypass surgery in 2003 and 2004 scared her about dying. The doctors were impressed by how well she recovered, and her own family thought of her as invulnerable. This put her under enormous pressure: "I had to be strong for everybody. If I break down in pieces my entire family breaks down. So I shut it [my heart condition] out of my mind because that was the only way I could survive."

She admitted that she became "greedy. It was too easy. No one was overseeing me. It was like an obsession, and a desire to help my sister." She went on to say: "It's like an addiction. I wanted to stop but I couldn't." This woman claimed that during the period in which she was stealing the money, it allowed her "to escape the harsh realities of what I was going through." But, she was "never at peace" and the offense "took its toll on my conscience and health."

PSYCHIATRIC HISTORY/ SUBSTANCE USE HISTORY:

Ms. Aspillera denied experiencing significant trauma or life threatening illness during her childhood. She did not have problems with anxiety or depression in her youth, nor did she experience symptoms of mania or psychosis.

In 2004, following the loss of her niece and brother in law, the stage 4 breast cancer in her sister and her own quintuple bypass surgery, illness, Ms. Aspillera began to suffer bouts of anxiety and depression. She initially believed she could manage her symptoms without medication, but family and friends noticed her deterioration which included weight loss, daily depressed mood, problems with concentration, low energy, and hypersomnia. Ms. Aspillera was ultimately prescribed Ambien for sleep.

She was never hospitalized for psychiatric reasons, or prescribed psychiatric medications. She was also never treated as an outpatient in psychotherapy or counseling. She has no known family history of mental illness.

Ms. Aspillera consumed alcohol socially, perhaps drinking a glass of wine once every six months. She has not drunk alcohol in the past four years and has never experimented with drugs.

PERSONAL AND SOCIAL HISTORY:

Ms. Aspillera was born and raised in Pasay City in the Philippines. She is unaware of any problems with her birth and said she reached her developmental milestones without delay. She has one brother (age 64) and three sisters (one age 69, one age 58, and one deceased). She is very close with her family. Her father died in 1991 at the age of 92, and is described as "loving, caring, thoughtful, very intelligent, he spoiled all of us - children and grandkids." She was his favorite child, she recalled. Her mother worked as a housewife, and was described as a "disciplinarian, she was our rock, a very good mother, the glue that kept our family together, caring." Ms. Aspillera enjoyed spending time together in activities such as shopping. Her parents remained together until their passing with a marriage that endured solidly for almost fifty years. Discipline was described as only somewhat strict with few rules. When Ms. Aspillera broke the rules, her mother would sit her down and talk to her. She denied ever being physically, emotionally or sexually abused.

Ms. Aspillera attended two elementary schools (due to relocation) and was never held back or placed in special education classes. She reported doing well in school and denied any problems with attention, hyperactivity, truancy, daydreaming and cheating. Ms. Aspillera was consistently among the top ten percent of students in middle school. During high school, she continued to excel and participated in drama. She believed she was perceived as a leader. She graduate from high school with a 3.5 GPA, then attended college at the Philippine Women's University. Although she did not graduate, she completed four years and was only about six units short of her Bachelors of

Science in Business Administration. Ms. Aspillera additionally holds an interior design certificate. She immigrated to the United States in 1980, at the age of 35.

This woman has a strong work ethic. She most recently worked for nine years as an Executive Coordinator/Client Service Specialist at Ernst & Young. Performance evaluations of her executive administration and client service duties were reportedly excellent until the offense. Prior to this she worked as an Assistant to the President at BHP Copper for two years. Performance evaluations of her executive administration duties were excellent. Before that she worked as a trade assistant for the Canadian Consulate for four years, and prior to that she was Executive Administrator to the Nigerian Consulate four years. Other jobs she has held include working as an Executive Assistant for Macy's, and for Homestake Mining. Ms. Aspillera has been unemployed since 2008. The defendant has not made any decision about future employment, but is eager "to get back on [her] feet, move on, and start a new life."

Ms. Aspillera reports that her finances are not in good standing. She has received a personal loan which she paid back. Her credit rating is low. Ms. Aspillera never served in the military.

The defendant has been married once. She has a close relationship with her husband, her only serious relationship. Ms. Aspillera has three children.

Ms. Aspillera currently suffers from diabetes, heart disease, gout, and high blood pressure. For these illnesses, she is currently taking a variety of medicines including Flavix, Metformin, Glipizid, Liseprinol, and Aspirin.

She reports that her heart condition scared her about dying. The doctors told her she could drop dead at any time and she repressed her anxieties surrounding it. "I shut it out of my mind because that was the only way I could survive. I had to be strong for everybody. If I break down in pieces my entire family breaks down."

MENTAL STATUS EXAMINATION

Ms. Aspillera was on time for our interview. She was dressed casually and appeared healthy and clean. She displayed no unusual body movements or mannerisms. Her speech was articulate with a normal rate and volume. She was alert and managed to follow the flow of the interview. Her attitude was friendly, engageable and cooperative.

Ms. Aspillera displayed a full range of affect. She appeared depressed, and reported

a sense of hopelessness and helplessness. This woman was regretful, remorseful, fretful, fearful, and anxious about her situation. She was not irritable or euphoric. Her affect was congruent to the situation and her thinking. Her mood was reported as "very depressed." She said her appetite has been diminished and that she has lost a significant amount of weight. She denied having nightmares but her sleep is interrupted by "dark thoughts" and she is averaging only two hours per night.

The defendant's thought process was clear, coherent and goal directed. She can read, pay attention and concentrate. Her capacity for abstract reasoning was intact. Ms. Aspillera's immediate memory was good and she recalled remote events easily. Her thought content was appropriate to the situation and contained no paranoia. Ms. Aspillera reported no abnormalities such as auditory or visual hallucinations/illusions, and she did not appear to be internally preoccupied.

This woman reported no current suicidal or homicidal ideation. Her impulse control and judgment were adequate. Her capacity for insight was limited.

PSYCHOLOGICAL TESTING RESULTS

Observations and test taking behaviors: Ms. Aspillera was cooperative with all aspects of the testing process and appeared motivated to do her best. She was able to hear questions and instructions presented at normal conversational volume. Nonverbal and verbal communication was consistent. She completed the required procedures as requested. Overall, these results appear to be a valid indicator of her current psychological functioning.

Intellectual/Cognitive Functioning: Ms. Aspillera's performance on the Shipley Institute of Living Scale-2 yielded a composite standard score of 84, which falls at the 14th percentile rank. This suggests her overall cognitive abilities are in the **below average** range of adult intelligence. Further analysis indicates her vocabulary score was in the average range, and her abstraction score was in the well below average range. This is a large enough discrepancy such that her AQ score of 61.85 indicates that there are highly probable Shipley signs of cognitive impairment. Given Ms. Aspillera's age, educational background and vocabulary knowledge, we would have expected her to perform better on the abstract portion of the test. She seems to be having a problem with pattern recognition, sequential processing and abstract reasoning. Ms. Aspillera is currently not functioning at a level consistent with her optimum intellectual capabilities. In the absence of a head injury or neurological illness, psychogenic factors may be interfering with the efficiency of her cognitive operations.

Psychological Functioning: Analysis of the validity and modifier indices of the self-report psychological inventories reveals both the CPI and the MCMI-III to be valid for interpretation.

The psychologic test data are consistent in showing signs of depression. Specific test signs of depression include a significant elevation of the MCMI-III Major Depressive Disorder (BR=80), an intermediate elevation of the MCMI-III Dysthymic Disorder (BR=70), and a Beck Inventory score of 45, which falls in the severe range of depressive symptomatology. In particular, she states that she feels guilty all the time, dislikes herself, blames herself for everything bad that happened, feels utterly worthless and has thoughts of killing herself but would not carry them out.

The Rotter Incomplete Sentences reveal themes of regret and emotional distress. For example, she states: "I regret committing the crime…I am very sorry for what I did…What pains me is the humiliation and pain I brought my family…I failed miserably…My mind is so confused...I hate myself…I suffer from deep depression and anxiety…I feel sad, depressed, angry at myself, scared…I can't function...My nerves are frazzled...I need to be strong for my family...I wish things could be different...The future is bleak."

The CPI indicates that Ms. Aspillera has important personality strengths. She tests as a person who is private, reserved, inwardly oriented and conventional. This type of person is assertive, responsible and usually asks little for themselves, giving much to others. Ms. Aspillera is likely to have a good measure of self-control and in most situations inhibits herself.

The MCMI-III reveals some personality tendencies in which she is lacking vitality, is disciplined and very regulated. Frequently individuals with this personality style are highly organized and perfectionistic. Interpersonally, she is somewhat withdrawn from others but polite and respectful of social conventions and proprieties. Cognitively, Ms. Aspillera's thoughts tend to be constricted and her self-image slightly complacent. She is not introspective, but she is conscientious, industrious and meticulous. Her intrapsychic organization tends to be compartmentalized.

DISCUSSION AND OPINION:

Ms. Aspillera is an elderly woman who has pled guilty to fraud and embezzlement and is awaiting sentencing. She was referred for psychological assessment in order to

help explain the behavior that led to the instant offense, and to determine if there were factors in mitigation relevant to sentencing.

The instant offense is striking in that it took place over many years and involved so much money. How could a basically good person do something so unconscionable? What would lead this woman, who had no history of anti-social behavior and no criminal record, to repeatedly suspend her moral compass and behave in a way that was so out of character?

The clinical interview revealed Ms. Aspillera to be genuinely remorseful and regretful. This religious woman feels that she sinned, and is repentant in every sense of the word. Although she is quick to condemn herself for her behavior, she is slow to understand how the events of her life preceding and during the offense contributed to the crime. She was aware of the immediate cause of her embezzlement: wanting to send her sister money for medical care, and she appreciated how a lack of supervision and easy access to the funds created the opportunity. She was partially correct in describing her dependence on the money and the difficulty of stopping the stealing as an "addiction." But Ms. Aspillera was not at all appreciative of the role played by the tremendous vulnerability and anxiety about death that crept into her life at about the same time she started to embezzle funds.

Following her first angioplasty in 2003, this woman was subjected to a string of losses and life threatening illness in her family. In a devastating and demoralizing 2004, Ms. Aspillera learned of her sister's stage four breast cancer, and experienced the death of her niece and brother in law. Then, in September 2004, she had a massive heart attack and required quintuple bypass surgery. This woman was face to face with death, her own and that of members of her family. It was terrifying, and she lacked the psychological maturity to cope with such stress.

The fact that her husband was no longer working due to his medical condition placed even more strain on her. The reality was that she had a good job, was making a good salary and didn't need to steal from her client. The impulse was irrational, and in my analysis, came from a sense of fragility and fear. In an unconscious calculation, the funds she stole were proportional to the level of her anxiety, and an attempt to allay her concerns about death and dying.

Psychological testing data were consistent with the interview findings. Ms. Aspillera is significantly depressed. She is withdrawn and feeling isolated. This woman tests as an assertive, responsible and conventional person. There are compulsive personality

trends that make her rigid, meticulous and formal. There were no test indications of anti-social, narcissistic or sadistic-aggressive tendencies. She is not a psychopath.

I would like to take this opportunity to indicate for the record that great care was given to assessing whether or not Ms. Aspillera might be malingering, since symptom over-reporting to avoid responsibility or to obtain special dispensations is always a concern in forensic evaluations. It is my opinion that Ms. Aspillera is not malingering and is suffering from a genuine depression. Moreover, Ms. Aspillera made no effort to fabricate an explanation or excuse for her fraud and embezzlement. Instead, she has owned up to her mistake in full.

Thank you very much for referring this very interesting case.

Sincerely,

Paul Good, Ph.D.
Clinical and Forensic Psychologist

MRN: 12862202 Visit #: 17504911
Patient Name: ASPILLERA, Lily C Provider: Thorson, Anne I
Date Entered: 05/30/10 20:04 Date of Service: 04/21/10 00:01

Cardiology Note

UCSF CARDIOLOGY

350 Parnassus Avenue Suite 300 Box 0327 San Francisco, CA 94143	505 Parnassus Avenue Room M-1176 Box 0124 San Francisco, CA 94143	1300 South Eliseo Drive Suite 204, Greenbrae Box 0327 San Francisco, CA 94143
Tel: (415) 353-2873	Tel: (415) 476-1326	Tel: (415) 353-2873
Fax: (415) 353-2528	Fax: (415) 502-8627	Fax: (415) 353-2528

CARDIOLOGY CLINIC AT 350 PARNASSUS
CARDIOLOGY CLINIC AT 505 PARNASSUS
CARDIOLOGY CLINIC AT GREENBRAE

April 21, 2010
RE:
U#: 12862202
SERVICE DATE: 04/21/10
CHIEF COMPLAINT/HISTORY OF PRESENT ILLNESS: This patient returns to the Cardiology Clinic today, April 21st, 2010 for a follow-up visit. She states that since her previous visit, she has been under a tremendous amount of stress with her husband being ill with severe cardiomyopathy. She has essentially had to take over his care including helping him with medications. She states that she is providing essentially full-time care and this has not allowed her to take adequate care of herself. She has been checking her blood sugars sporadically but states that they seem to be under slightly better control. She is worried about her blood pressure given the recent stress she has been under. She does not describe any chest discomfort, arm, neck or jaw pain. She has not experienced any shortness of breath at rest and denies dyspnea on exertion or effort intolerance except that she notes she is more fatigued than usual.
She denies paroxysmal nocturnal dyspnea, orthopnea or lower extremity edema. She does not report any recent palpitations, rapid or irregular heartbeat, lightheadedness or presyncope.
PAST MEDICAL HISTORY: Her past medical history is significant for:
1. Gout.
2. Hypertension.
3. Coronary artery disease, status-post coronary artery bypass

MRN: 12862202 Visit #: 17504911
Patient Name: ASPILLERA, Lily C Provider: Thorson, Anne I
Date Entered: 05/30/10 20:04 Date of Service: 04/21/10 00:01

Cardiology Note (continued)

surgery.
4. Seborrheic dermatitis.
5. Diabetes mellitus.
6. History of post-cardiotomy pericarditis.
CURRENT MEDICATIONS: Her current medications are as listed on the STOR sheet.
ALLERGIES: She has no known drug allergies.
Family history and social history were reviewed from prior date July 18th, 2007 and are without significant change.
REVIEW OF SYSTEMS: Review of systems is pertinent for recent difficulty sleeping, increased stress and anxiety, occasional headache, decreased visual acuity, occasional dyspepsia, and intermittent nocturia. The remainder of the review of systems is negative.
PHYSICAL EXAMINATION: On physical examination today, blood pressure is 139/62, heart rate is 89, respirations 14, oxygen saturation 99% on room air. Weight is 113.5 lbs and temperature 36.5 . In general, she is a well developed, thin, fatigued appearing woman in no acute distress. HEENT exam atraumatic, normocephalic. Eyes pupils equal, round, reactive to light, extra ocular movements intact. Sclera are anicteric. Oropharynx is clear. Neck is supple, no lymphadenopathy or thyromegaly. Jugular venous pressure is 7 cm. Carotid upstroke is normal without bruit. Chest is clear to auscultation and percussion without wheezes or rales. Cardiac exam reveals regular rhythm, S1 and S2 are normal, and I could appreciate no gallop or rub. Abdomen is soft, non-tender. Normal active bowel sounds are present. Extremity exam reveals no cyanosis, clubbing or edema and the distal pulses are 1+ and symmetric. Neurologic exam is non-focal.
LABORATORY STUDIES: No recent laboratory data is available for review.

IMPRESSION / PLAN:
1. Coronary artery disease, status-post coronary artery bypass surgery and stent placement with no symptoms of active ischemia and negative recent stress test. We will continue the current medication regimen.
2. Hypertension, better control now on the current medications. We will continue the Toprol XL 75 mg daily; she is to keep a log of her blood pressures and if they are over 146 systolic, I have recommended that she up-titrate the Toprol to 100 mg daily.
3. Diabetes mellitus, still sub-optimal hemoglobin A1c. She will follow-up with her primary care physician regarding management.

MRN: 12862202 Visit #: 17504911
Patient Name: ASPILLERA, Lily C Provider: Thorson, Anne I
Date Entered: 05/30/10 20:04 Date of Service: 04/21/10 00:01

Cardiology Note (continued)

4. Hyperlipidemia, no recent laboratory data available for review. We will check cholesterol, cholesterol fractions and liver function tests with her next blood evaluation. She will continue Lipitor and we will adjust the dosage depending on her blood test results. I have again counseled her regarding a diet and exercise program.
She will return to see us in six months or as needed.

ANNE THORSON, M.D.
ASSOCIATE CLINICAL PROFESSOR
EXTRA COPIES:

CARBON COPIES:

DICTATED BY: Anne I. Thorson, MD 12344

Electronically Signed by
Anne I. Thorson, MD 06/01/2010 10:47 A

ATTENDING PHYSICIAN: Anne I. Thorson, MD 12344
D: 05/30/2010 08:04 P
T: 05/31/2010 09:18 A a42 CS#: 2390017

Signed by: Thorson, Anne I 12344
Electronically Signed: 06/01/10 10:47

UNIT NUMBER

PT. NAME 128 bb 99-2 IP CAR
BIRTHDATE AGUILERA, HECTOR NOEL
DOB 03/16/1942 67 M
1102129 ADM DT 12/28/2009
LOCATION DATE

UCSF Medical Center

Complete Page 1 for ALL patients.
Complete additional Pages 2 and 3 for ALL Home Care, SNF, and Transfer patients.

PATIENT DISCHARGE PLAN (PDP)

Admit Date	Discharge Date	Discharge Time	Attending Physician and ID#	Service	ICD CODES
12/28/09	12/31/09	2pm	Foster	Cards 4	

Principal Diagnosis: Heart Failure

Secondary Diagnoses: Acute renal failure, Dm, Chronic Kidney Disease, Afib on coumadin, Coumadin overdose

Principal Procedure	Date:
Other Procedure #2	Date:
Other Procedure #3	Date:
Other Procedure #4	Date:

If patient had more than 4 procedures please record procedure/date below for benefit of primary M.D.

Discharge Condition: ☐ Good ☒ Fair ☐ Poor

Disposition: ☑ Home ☐ Home w/ services ☐ SNF ☐ Acute Rehab ☐ Left "Against Medical Advice" ☐ Expired ☐ Other Facility: _____ ☐ Other Hospital: _____

Discharge Diet: ☐ No restrictions ☑ Carbohydrate Controlled ☐ Dysphagia/Soft Chewable ☑ Renal ☑ Low Sodium ☑ Fluid Restriction: 1200mL/day ☐ Other: _____

Activity Level: ☑ No restrictions ☐ Walk at least ___ x day ☐ No bending/twisting of spine ☐ No strenuous activity ☐ Bedrest ☐ Out of bed to chair for meals ☐ No driving: _____days ☐ Do not lift >20 lbs ☐ OK to shower/tub ☐ Limit sitting duration: ___ minutes ☐ Other: _____

Clinical Summary and Post-Discharge Objectives: (see dictation # _____ for a detailed summary)

67M h/o non-ischemic DCM, CKD, DM who p/w ARF. Given his poor RV systolic function he was placed on a dobutamine gtt and his lasix was held. After 48 hrs, he experienced a significant improvement in his renal function with a Cr of 3.1 from 4.3 on admission. Renal was consulted who thought he was pre-renal vs cardiorenal syndrome and will continue to follow him as an outpt. Heart Failure was also consulted and will evaluate him for a heart transplant as an outpt. He was also supratherapeutic on coumadin w/ an INR=5.1. His coumadin was held and his dose was decreased. The plan for him to follow up at clinic as below.

Future Goals:

M.D. Responsible for Dictation and ID#: Sanes 75978

M.D. Completing this form and ID#: Sanes 75978

Follow-Up Care and Referrals

Provider Name	Clinic	Location	Date	Time
Francine Deier	Anticoag clinic		1/5	9:30 AM
Dana McGlothlin	Heart Failure	400 Parnassus	1/28	9:45 AM
Echo / Dr. Thomson	Cardiology clinic		3/10/10	1:5 pm
Renal clinic will contact pt for an appt				
Cardiac EP clinic will contact pt for an appt				

University of California San Francisco
Coding Summary

JAN 0 8 2010

Print Date: 1/6/2010 4:00:27PM

Patient Name: **Aspillera, Hector N** Billing Number: **17027249** MRN: **12866992**

Date of Birth:	**3/16/1942**	Sex: **MALE**	SSN: **547655810**
Age at Admit:	**67 years**	Race: **NATIVE HAWAIIAN / OTH PACIFIC ISLANDER**	
Admit Date/Time:	**12/28/09 11:23 pm**	Disch Date/Time: **12/31/09 4:04 pm**	Total Charges: **$ 29,931.66**
Attend Phys:	**00050783 Foster, Elyse**	Financial Class: **J MEDICARE PART B ONLY**	
Patient Type:	**I INPATIENT**	Payor 1: **B01 MEDICARE A I/P TEC**	
Det Pt Type:	**IP INPATIENT**	Payor 2:	
Disch Service:	**CAR CARDIOLOGY**	Payor 3:	
Admit Dx:	**584.9 Acute kidney failure NOS**	Discharge Status: **ROU HOME**	

DRG	Description	MDC	Weight	GMLOS	ALOS	Expect Reimb	Coder ID	Coded Date	Final Date
291	HEART FAILURE & SHOCK W MCC	005	1.4609	5.00	6.40	$ 540,202	MACDONAD	01/06/2010	01/06/2010

APR DRG	Description	APR MDC	APR SOI	APR ROM	APR DRG Weight
194	HEART FAILURE	005	3	3	1.3262

Seq	Diagnosis	POA	Description	APR ROM Level	APR SOI Level
1	428.0	Y	Congestive heart failure, unspecified	P-Principal diagnosis used for SOI/ROM calculation	P-Principal diagnosis used for SOI/ROM calculation
2	584.9	Y	Acute kidney failure, unspecified	4-Extreme	4-Extreme
3	427.31	Y	Atrial fibrillation	2-Moderate	1-Minor
4	250.00	Y	Diabetes mellitus without complication, type II or unspecified type, not stated as uncontrolled	1-Minor	1-Minor
5	403.90	Y	Hypertensive chronic kidney disease stage I through stage IV, or unspecified, unspecified benign or malignant	2-Moderate	2-Moderate
6	585.9	Y	Chronic kidney disease, unspecified	1-Minor	1-Minor
7	285.21	Y	Anemia in chronic kidney disease	1-Minor	1-Minor

Seq/Ep	Procedure	Modifiers 1 2 3 4 5	Start	End	Provider	Role

Consult Performed By

00038494 Shaw, Robin M
00040215 Cho, Kerry C

UNIT NUMBER

PT. NAME
128 bb 99-2 IP CAR
BIRTHDATE ILLERA, HECTOR NOEL
DOB 03/16/1942 67 M
1102749 ADM DT 12/28/2009

LOCATION DATE

UCSF Medical Center

DISCHARGE/FOLLOW-UP SUMMARY
PLEASE BRING THIS WITH YOU TO YOUR FIRST DOCTOR VISIT

Diagnosis/Surgeries/Procedures: Heart failure, acute renal failure, PN, chronic kidney disease, AFib on coumadin, coumadin overdose

Doctor at the time of discharge: Foster

Discharge to: ☒ Home ☐ Acute facility ☐ Sub-acute facility ☐ Acute rehab ☐ Hospital based SNF
☐ Free standing SNF ☐ I/P Hospice ☐ Med psych ☐ Other (Specify) _____

Name of facility _____

Person accepting responsibility for patient: ☒ self ☐ family ☐ other _____

Mode of transportation: ☒ self/family ☐ taxi ☐ ambulance/phone # _____ pick up date/time _____

Referrals / Follow-up for your care

Follow-up	Location	Phone #	Appointment/Delivery Date/Time
Dr. Francine Deier	Anticoagulation Clinic		1/5/10 0930 am
Dr. Dana McGlothlin	Heart failure 400 Parnassus		1/28 945 am
Dr. echo / Dr. Thornton	Cardiology clinic		3/10/10 1:15 pm
☐ ~~Home Care Agency~~: Renal and cardiac RN will contact patient with appts.			
☐ RN ☐ PT/OT ☐ Home health aid ☐ SW ☐ _____			
☐ Infusion Company:			
☐ Equipment Company:			
☐ cane/walker ☐ crutches/wheelchair ☐ oxygen ☐ commode ☐ hospital bed ☐ _____			
☐ Supply Company			
☐ ostomy ☐ tracheostomy ☐ wounds ☐ tube feedings			

☑ If you smoke, STOP ALL smoking/tobacco use. *(Access our patient education library online at www.ucsfhealth.org for additional information)*

Discharge Instructions until your first doctor's appointment:

Name(s) of teaching record(s) for self care instructions: _____ ☐ none

Medications: ☐ none ☒ reviewed by my nurse ☐ resume pre-hospital medications ☐ prescriptions reviewed by my doctor
☐ see Medication Schedule (complex meds) as per doctor's orders
☐ reviewed by my pharmacist

DISCHARGE INSTRUCTIONS FOR PATIENTS WHO DO NOT RECEIVE A TEACHING RECORD:

Name(s) of pamphlet(s) given to patient: Fluid Restriction of 1200 ml/day ☐ none

Diet: ☐ no restrictions ☒ special diet (specify) Low Sodium, Carbohydrate controlled, renal

Activity: ☒ no restrictions ☐ no lifting > 10 pounds for _____ days ☐ no shower/tub for _____ days
☐ no driving for _____ days ☐ other _____

Treatments prescribed by your doctor: ☐ none ☐ incisional care _____

☐ place dry dressing on _____ after bathing ☐ place wet to damp dressing on(site) _____ every _____

☐ use nebulizer/inhaler every _____

☐ taught _____ with return demonstration.

Notify your doctor if you have any of .the following, especially:

☒ fever	☒ blood sugar < 70 or > 400	☒ shortness of breathing/wheezing	☒ dizziness/fainting
☐ worse pain	☐ drainage from wound	☒ burning, urgency, freq. of urination	☒ palpitations
☒ numbness	☐ bleeding from wound	☒ blurry vision	☐ chest pain **not relieved by Nitro**
☐ redness near wound		☒ headache	☒ new onset chest pain
☐ other _____			☒ swelling rapid weight gain
			☒ confusion/seizures

Signatures: I understand the above instructions and have a copy of them. ☐ Interpreter used

Discharge RN: K Colbert Patient/Family: [signature]

Other instructor/title: _____ Social Worker: _____

Other instructor/title: _____ Discharge date/time: _____

602-440Z (Rev. 05/08) WorkflowOne ORIGINAL – MEDICAL RECORD COPY YELLOW – PATIENT COPY PINK – NURSING COPY

UCSF Medical Center
505 Parnassus Ave., San Francisco, CA 94143
(415) 476-1000

UCSF Children's Hospital

UNIT NUMBER

PT. NAME

BIRTHDATE 12 8 66 99-2 IP CAR
ASPILLERA, HECTOR NOEL
DOB 03/16/1942 67 M
1702749 ADM DT 12/28/200

LOCATION DATE

DISCHARGE PRESCRIPTION & MEDICATION LIST

PLEASE BRING THIS LIST TO YOUR PHARMACY AND ALL CLINIC VISITS

PROVIDERS: MAKE SURE TO RECONCILE ALL PRE-HOSPITALIZATION AND CURRENT MEDICATIONS. LIST ALL MEDICATIONS THAT WILL BE TAKEN AFTER DISCHARGE, INCLUDING HERBALS AND OTC'S.

PATIENT'S ALLERGIES _____ ☑ NKDA WT____KG

THE PATIENT WILL BE TAKING THESE MEDICATIONS:

EL PACIENTE ESTARÁ TOMANDO ESTOS MEDICAMENTOS / 病人要服用以下藥物：

For transfers to outside facilities
Check this box to indicate that the patient already has this medication at home

	MEDICATION NAME	STRENGTH	QTY	DIRECTIONS	# OF REFILLS	DO NOT FILL	TIME OF LAST DOSE
1	Digoxin	0.125mg	30	Po every other day	0		
2	ASA	81mg	30	Po daily	0		
3	Amiodarone	200mg	30	Po as directed	0		
4	Lasix	80mg	60	Po BID	0		
5	Lasix	40mg	60	Po BID	0		
6	Revil	10mg	30	Po daily	0		
7	~~Protonix~~ Omeprazole	40mg	30	Po daily	0		
8	Niacin	500mg	30	Po daily	0		
9	Glyburide	10mg	60	Po BID	0		
10	Metformin	500mg	60	Po BID	0		
11	Coreg	100mg	60	Po BID	0		
12	Potassium Chloride	10 mEq	30	Po daily	0		
	~~Coumadin 2mg 2 PO QHS 4/2 and 4/4~~				0		

RN Initials

THE PATIENT WILL NOT BE TAKING THESE MEDICATIONS ANYMORE:

EL PACIENTE YA NO ESTARÁ TOMANDO ESTOS MEDICAMENTOS NUNCA MAS / 病人不要服用以下藥物：

STOP 1 Enalapril	STOP 4
STOP 2 Metoprolol	STOP 5
STOP 3	STOP 6

PATIENT'S ADDRESS _____ DATE _____

PATIENT'S PHARMACY _____ TEL# ( ) _____ FAX# ( ) _____

PRIMARY PROVIDER _____ TEL# ( ) _____ FAX# ( ) _____

PRESCRIBER'S NAME (Print)	SIGNATURE		HOUSE OFFICER NAME (Print)		
Elyse Foster	56783		Tacara Somes		
CA LIC #	DEA #	PHONE/PAGER #	SIGNATURE		PHONE/PAGER #
G69541	AF2548064	353 1601	7578	75978	353 1601

PHARMACIST NAME (Print)	SIGNATURE

☐ This Form Faxed to Primary Care Provider
Prescription-Pharmacy Status: ☐ Called ☐ Faxed ☐ Given to patient

FOR PROBLEMS FILLING THIS PRESCRIPTION, PLEASE CALL (415) _____ (☐ phone ☐ pager)

104-0012 (Rev. 5/08) WorkflowOne ORIGINAL - PHARMACY COPY WHITE - MEDICAL RECORD COPY YELLOW - PATIENT COPY

UCSF Medical Center
505 Parnassus Ave., San Francisco, CA 94143
(415) 476-1000

UCSF Children's Hospital

UNIT NUMBER

PT. NAME

BIRTHDATE

I28 66 99-2 IP CAR
ASPILLERA,HECTOR NOEL
DOB 03/16/1942 67 M
LOCATION 17027249 ADM DT DATE 12/28/2009

DISCHARGE PRESCRIPTION & MEDICATION LIST

PLEASE BRING THIS LIST TO YOUR PHARMACY AND ALL CLINIC VISITS

PROVIDERS: MAKE SURE TO RECONCILE ALL PRE-HOSPITALIZATION AND CURRENT MEDICATIONS. LIST ALL MEDICATIONS THAT WILL BE TAKEN AFTER DISCHARGE, INCLUDING HERBALS AND OTC'S.

PATIENT'S ALLERGIES _____ ☐ NKDA WT_____KG

THE PATIENT WILL BE TAKING THESE MEDICATIONS:

EL PACIENTE ESTARÁ TOMANDO ESTOS MEDICAMENTOS / 病人要服用以下藥物：

For transfers to outside facilities: Check this box to indicate that the patient already has this medication at home

	MEDICATION NAME	STRENGTH	QTY	DIRECTIONS	# OF REFILLS	DO NOT FILL	TIME OF LAST DOSE
1	Coumadin	2mg	2	PO 1/1 and 1/3	ϕ		
2	Coumadin	1.5mg	2	PO 1/2 and 1/4	ϕ		
3							
4							
5							
6							
7							
8							
9							
10							
11							
12							

RN Initials

THE PATIENT WILL NOT BE TAKING THESE MEDICATIONS ANYMORE:

EL PACIENTE YA NO ESTARÁ TOMANDO ESTOS MEDICAMENTOS NUNCA MAS / 病人不要服用以下藥物：

STOP 1	STOP 4
STOP 2	STOP 5
STOP 3	STOP 6

PATIENT'S ADDRESS _____ DATE _____

PATIENT'S PHARMACY _____ TEL# ( ) _____ FAX# ( ) _____

PRIMARY PROVIDER _____ TEL# ( ) _____ FAX# ( ) _____

PRESCRIBER'S NAME (Print)	SIGNATURE	HOUSE OFFICER NAME (Print)	
Elyse Foster	50783	Tarere Sure	
CA LIC # / DEA # / PHONE/PAGER #		SIGNATURE	PHONE/PAGER #
G69541 / AF2548064 / 3531061		[signature] 75971	3531061

PHARMACIST NAME (Print)	SIGNATURE

☐ This Form Faxed to Primary Care Provider
Prescription-Pharmacy Status: ☐ Called ☐ Faxed ☐ Given to patient

FOR PROBLEMS FILLING THIS PRESCRIPTION, PLEASE CALL (415) _____ (☐ phone ☐ pager)

ORIGINAL - PHARMACY COPY WHITE - MEDICAL RECORD COPY YELLOW - PATIENT COPY

104-0012 (Rev. 5/08) WorkflowOne

U.C.S.F. MEDICAL CENTER, STOR/CDS SYSTEM

Patient Name: ASPILLERA, HECTOR NOEL
MRN: 1286699-2
DOB: 03/16/1942

Printed on 01-28-10 at 03:46 pm
Z123

DOCUMENT # 2281069 Prelim
VISIT # 17153712

DIVISION OF CARDIOLOGY
400 Parnassus Avenue
Sixth Floor, Box 0327
San Francisco, California 94143-0327
Tel: (415) 353-2873 Fax: (415) 353-2528
HEART TRANSPLANT CLINIC

January 28, 2010
rry C Cho, M.D.
Box 0532
UCSF Campus Mail
Anne I. Thorson, M.D.
Box 0214
UCSF Campus Mail
Danielle Anne Eigner
ox 1950
CSF Campus Mail
RE: x
U#: 12866992
DATE OF SERVICE: 01/28/10
Dear Colleagues:
We had the pleasure of seeing this patient at the University of California, San Francisco Advanced Heart Failure and Heart Transplantation Clinic on January 28, 2010, for evaluation and consideration for cardiac transplantation. As you know, he is a -year-old man with a history of non-ischemic dilated cardiomyopathy with last ejection fraction of 35-40%, ACC/AHA stage C, New York Heart Association class II to III heart failure symptoms who also has diabetes mellitus, chronic kidney disease, atrial fibrillation on Coumadin, hypertension and hyperlipidemia. He is here for initial evaluation for consideration for cardiac transplantation.
The patient was seen by the Congestive Heart Failure and Heart Transplant Service during his hospitalization in December 2009. At that time, the patient received inotropic therapy with dobutamine and was discharged with a plan for right heart catheterization to evaluate his filling pressures, given the fact that there was a feeling he may have been fluid overloaded. However, unfortunately, the patient did not receive his right heart catheterization and he presents to clinic today for formal evaluation.
The patient's heart failure history started in early 2008 when he was hospitalized for congestive heart failure and was diuresed for fluid verload. His initial symptoms were shortness of breath as well as swelling in the lower extremities. During his admission at UCSF, he underwent right and left heart catheterization, which revealed elevated left and right-sided filling pressures and diffuse coronary calcium, but no significant coronary artery disease to explain his low ejection fraction. He also had low cardiac output. Since his initial diagnosis

f heart failure in early 2008, the patient has been on medical therapy and under the care of a cardiologist. He had not been hospitalized for heart failure subsequently until December 2009 when, per the patient, he felt fatigue, shortness of breath with exertion and dehydration symptoms. Prior to his hospitalization, his Lasix had been increased to 80 mg twice daily and, although there was a component of heart failure during his admission and the patient was placed on inotropic therapy, it was unclear what his true filling pressures were. He was discharged on his medication regimen, but decreased on his Lasix regimen to 60 mg twice daily. He was taken off his ACE inhibitor which was enalapril prior to admission and has not been on this medication since. His creatinine during admission in December 2009 was as high as the 3 range and, although hemodialysis was considered at that time as a necessary option in the future, subsequent laboratory analysis has revealed that his creatinine has returned to 1.9. He has seen Renal as an outpatient, who does not feel hemodialysis is currently necessary and will continue to follow him. They do feel that an ACE inhibitor would not be harmful and, in fact, potentially beneficial for his proteinuria from their rspective. Per report, Dr. Thorson also has been considering starting ACE inhibition once again.

From a symptom perspective, the patient states that he has no chest pain at rest or with exertion. He denies any palpitations, syncope or lightheadedness. He denies any paroxysmal nocturnal dyspnea and has stable three-pillow orthopnea. He denies any lower extremity edema. At baseline, he is able to walk four blocks before he becomes fatigued and hort of breath. He is only able to walk one flight of stairs before he ecomes fatigued and short of breath. He is limited also by right knee pain. He said for the past 6 months, he has not been able to golf because of his worsening symptoms. The patient has recently seen Dr. Thorson in evaluation this month and has been scheduled to see Electrophysiology for consideration of ICD with Dr. Badhwar. He also received cardiopulmonary exercise testing, which revealed a VO2 of 8.2.

PAST MEDICAL HISTORY:

1. Non-ischemic dilated cardiomyopathy with last ejection fraction of 35-40% on echocardiogram performed in October 2009, ACC/AHA stage C, HA class II to III heart failure symptoms.
2. Atrial fibrillation on Coumadin for stroke prophylaxis.
3. Chronic kidney disease with acute on chronic renal failure on December 2009 hospital admission, now back to near baseline with a creatinine of 1.9.
4. Diabetes mellitus.
5. History of non-sustained ventricular tachycardia.
6. Hypertension.
7. Hyperlipidemia.

CURRENT MEDICATIONS:

1. Glyburide 10 mg twice daily.
2. Lipitor 20 mg once daily.
3. Metformin 500 mg twice daily.
4. Coumadin 1.25 mg one tablet daily, except one-half tablet on Tuesdays and Fridays.
5. Coreg 25 mg twice daily.
6. Lasix 60 mg twice daily.
7. Potassium 10 mEq daily.
8. Niaspan 500 mg once daily.
9. Omeprazole 40 mg once daily.
10. Digoxin 0.125 mg every other day.
11. Aspirin 81 mg once daily.

2. Paxil 10 mg once daily.
ALLERGIES: No known drug allergies.
SOCIAL HISTORY: He is a retired import-export businessman. He is married and lives with his wife in West Portal. He has three children and good support.
HABITS: He quit tobacco 30 years ago. He does not drink any alcohol and has no history of cocaine, crack or methamphetamine use.
FAMILY HISTORY: He denies any coronary artery disease or history of sudden cardiac death.
REVIEW OF SYSTEMS: Otherwise negative in detail, other than as listed in the history of present illness.
PHYSICAL EXAMINATION: Vital signs: Weight 167.2 pounds, height 5 feet 11 inches, temperature 36.1, heart rate 65, blood pressure 134/72, oxygen saturation 97% on room air. In general, he is alert and oriented x3, a pleasant Filipino male in no acute distress. HEENT: Normocephalic, atraumatic. Pupils are equal, round and reactive to light. Extraocular movements are intact. Sclerae are anicteric. Neck is supple without thyromegaly. Chest has scant crackles in bilateral bases. Cardiovascular exam: Jugular venous pressure is 14 cm of water with positive hepatojugular reflux. He does have a Kussmaul sign. Carotids are 2+ without bruits. Heart is irregularly irregular with a 2/6 systolic murmur at the apex. Point of maximal impulse is laterally displaced. There is no S3 or S4. There is no right ventricular heave or pulmonary artery tap. Abdomen is non-tender and non-distended. Liver is palpable 2 cm below the costal margin. Extremities are with 1+ edema. Pulses are 2+ throughout. Neurologic exam is grossly intact.
DATA ANALYSIS: EKG performed on January 19, 2010, reveals atrial fibrillation with low voltage QRS in the limb leads and non-specific ST-T changes in the lateral leads.
Most recent laboratory analysis was performed on January 26, 2010. His white count was 7.6, hematocrit 32.7, platelets 224, sodium 138, potassium 3.7, chloride 97, bicarbonate 30, BUN 19, creatinine 1.95. Most recent echocardiogram was performed on October 26, 2009. Ejection fraction was 38%. Left ventricular volume was normal. Mild left ventricular hypertrophy that was eccentric. His ejection fraction was between 35 and 40%. Global hypokinesis with regional variation. There was severe right atrial enlargement and severe left atrial enlargement. The aortic valve was sclerotic without restriction. Pulmonary artery systolic pressure was 46-51 with right atrial pressure 11-15. There was trace pericardial effusion. Right ventricular volume was mildly increased with right ventricular systolic function moderately reduced. The patient had an endomyocardial biopsy on May 20, 2008, that showed mild-to-moderate ---------- hypertrophy but no other active process. On cardiopulmonary exercise testing in January 2010, VO2 was 8.2 with an RER of 1.01.
IMPRESSION:
1. Non-ischemic cardiomyopathy, ACC/AHA stage C, New York Heart Association class II to III heart failure symptoms. It is unclear the etiology of his heart failure, which may be restrictive in nature. His VO2 of 8.2 performed this month shows poor exercise tolerance quantitatively and suggests that his disease process has worsened. He appears to be a potential candidate for cardiac transplantation. He is currently on medical therapy.
2. Atrial fibrillation, currently on Coumadin.
3. Chronic kidney disease with a baseline creatinine between 1.6 and 1.9, currently being evaluated by Nephrology.
4. Diabetes mellitus on medical therapy.

. History of non-sustained ventricular tachycardia, currently being evaluated for potential implantable cardioverter defibrillator by Electrophysiology.
6. Hypertension on medical therapy.
7. Hyperlipidemia on medical therapy.
PLAN:
1. Cardiomyopathy. Given the difficulty in assessing the patient's volume status and plans previously for right heart catheterization, we will proceed with right heart catheterization in this individual. We do believe for the treatment of his cardiomyopathy from a medical perspective that he would benefit from ACE inhibitor therapy. As a result, we defer to Dr. Thorson, but do believe that ACE inhibitor therapy should be administered. It appears, looking through Nephrology's recommendations, that they do agree that ACE inhibitors would be beneficial to the kidneys as well. Given his poor VO2 of 8.2 on his examination in January 2010, we do believe it is reasonable to start the cardiac transplantation work-up process. We will start with a right heart catheterization to evaluate his filling pressures and decide he needs further aggressive therapy. From there, we will continue with a full cardiac transplantation work-up depending on the results of his right heart catheterization. Given his poor glomerular filtration rate and his baseline chronic kidney disease, he would have to be considered for potential heart and kidney transplantation if he were to be a candidate. Therefore, he would require referral to Kidney Transplant Unit for evaluation.
. Atrial fibrillation. He will continue on Coumadin.
. Chronic kidney disease. He will need to be evaluated by Kidney Transplant Unit if we decide that he is a cardiac transplantation candidate.
4. Diabetes. He should continue on his diabetic regimen.
5. Hypertension. As stated previously, we encouraged institution of ACE inhibitor therapy as per Dr. Anne Thorson with frequent monitoring of his creatinine and potassium.
Thank you for allowing us to participate in the care of this gentleman. We will follow up the results of the above tests and see him in _llowup, likely for consideration of full transplantation work-up.
Sincerely,
KATHLEEN L. TONG, M.D.
CLINICAL INSTRUCTOR
I have seen and examined the patient. I have reviewed and discussed the case with Dr. Jonathan C Hsu and agree with the findings and treatment plan as documented above.
EXTRA COPIES:
CARBON COPIES:
DICTATED BY: Jonathan C Hsu, MD 72338
PRELIMINARY REPORT

ATTENDING PHYSICIAN: Kathleen L Tong, M.D. 75450
D: 01/28/2010 12:30 P
T: 01/28/2010 03:28 P web CS#: 2281069

U.C.S.F. MEDICAL CENTER, STOR/CDS SYSTEM

Patient Name: ASPILLERA, HECTOR NOEL
MRN: 1286699-2
DOB: 03/16/1942

Printed on 01-28-10 at 12:09 pm
Z123

DOCUMENT # 2278223 Signed
VISIT # 17088801

UCSF CARDIOLOGY

350 Parnassus Avenue
Suite 300
Box 0327
San Francisco, CA 94143
Tel: (415) 353-2873
Fax: (415) 353-2528

505 Parnassus Avenue
Room M-1176
Box 0124
San Francisco, CA 94143
Tel: (415) 476-1326
Fax: (415) 502-8627

1300 South Eliseo Drive
Suite 204, Greenbrae
Box 0327
San Francisco, CA 94143
Tel: (415) 353-2873
Fax: (415) 353-2528

CARDIOLOGY CLINIC AT 350 PARNASSUS
CARDIOLOGY CLINIC AT 505 PARNASSUS
CARDIOLOGY CLINIC AT GREENBRAE

RE:
U#: 12866992
DATE OF SERVICE: 01/13/10
CHIEF COMPLAINT/HISTORY OF PRESENT ILLNESS: The patient returns to Cardiology Clinic today, January 13, 2010, for a followup visit. The patient was recently hospitalized for decompensated congestive heart failure and acute-on-chronic renal failure. He had initiation of intravenous dobutamine therapy and intravenous diuretics. He was seen in consultation by the renal service, who did not feel dialysis was necessary at this time. He diuresed well over the course of the hospitalization and was discharged home with outpatient followup. He states that, since he has been home from the hospital, he has generally felt much better. Specifically, his appetite has improved, and he feels less fatigued and less short of breath. He denies any chest discomfort, arm, neck, or jaw pain. He does not experience shortness of breath at rest but continues to have dyspnea on mild-to-moderate exertion, although he feels that this is improved since discharge from the hospital.
He denies paroxysmal nocturnal dyspnea, orthopnea, or increased lower extremity edema. He does note occasional palpitations or skipped heartbeats and rare episodes of lightheadedness. He has not had any syncope.
PAST MEDICAL HISTORY: Past medical history is significant for:
1. Nonischemic dilated cardiomyopathy.
2. Acute-on-chronic renal failure.
3. Anemia.
4. Atrial fibrillation.
5. Chronic anticoagulation therapy.
6. Diabetes mellitus.
7. Hypertension.
8. Hyperlipidemia.

CURRENT MEDICATIONS: Current medications are as listed on the STOR sheet.
ALLERGIES: He has no known drug allergies.

AMILY HISTORY: This was reviewed from hospitalization date December 31, 2009, and is without significant change.
SOCIAL HISTORY: This was reviewed from hospitalization date December 31, 2009, and is without significant change.
REVIEW OF SYSTEMS: Review of systems is pertinent for occasional difficulty sleeping, intermittent fatigue, dyspnea on exertion (as above), occasional nocturia, and decreased appetite. The remainder of the review of systems is negative.
PHYSICAL EXAMINATION:
VITAL SIGNS: On physical examination today, blood pressure is 110/70. Heart rate is 80. Respirations are 16. Oxygen saturation is 97% on room air.
GENERAL: He is a well-developed, well-nourished male in no acute distress.
HEENT: HEENT is atraumatic, normocephalic. Eyes show pupils are equal, round, and reactive to light. External ocular movements are intact. Sclerae are anicteric. Oropharynx is clear.
NECK: Neck is supple with no lymphadenopathy or thyromegaly. Jugular nous pressure is 10 cm. Carotid upstroke is normal without bruit.
CHEST: Chest exam reveals decreased breath sounds at the bases with bibasilar crackles. There are no wheezes.
CARDIAC: Cardiac exam reveals an irregularly irregular rhythm with intermittent S3. There is a grade 2/6 systolic ejection murmur heard at the left sternal border.
ABDOMEN: Abdomen is soft and nontender. I could not appreciate a liver dge.
EXTREMITIES: Extremity exam reveals no cyanosis, clubbing, or edema. Distal pulses are 1+ and symmetric.
NEUROLOGIC: Neurologic exam is nonfocal.
LABORATORY DATA: Most recent laboratory data available for review demonstrates a hematocrit of 33, potassium 3.7, BUN 44, creatinine 3.11, glucose 93, and normal liver function tests.
IMPRESSION/PLAN:
1. Ischemic cardiomyopathy with class III New York Heart Association mptoms, improved with additional diuresis. We will continue his rrent medication regimen. I will check laboratories today to check his potassium and his renal function.
2. Palpitations, with known nonsustained ventricular tachycardia. We will repeat his event monitor now. I suspect that he will continue to exhibit some nonsustained ventricular tachycardia and could benefit from implantable cardioverter-defibrillator placement. He has seen Dr. Natish Badhwar in Electrophysiology in the past for consideration of biventricular pacing and implantable cardioverter-defibrillator placement. I will refer him back to Dr. Badhwar for further discussion given his deterioration in status.
3. Decompensated heart failure. I will send the patient for a maximal venous oxygen consumption study to see whether he should now be referred for possible heart ransplant given his recent decompensation. He will see me in followup after the exercise study has been performed and I will refer him to the CHF/Transplant clinic.
ANNE I. THORSON, M.D.
SSOCIATE CLINICAL PROFESSOR
CARDIOLOGY FACULTY PRACTICE
EXTRA COPIES:
CARBON COPIES:
DICTATED BY: Anne I. Thorson, MD 12344
Electronically Signed by

Anne I. Thorson, MD 01/26/2010 05:42 P

Anne I. Thorson, MD 12344

ATTENDING PHYSICIAN:
D: 01/26/2010 06:04 A
T: 01/26/2010 06:33 A wds CS#: 2278223